

## **TRIAL EXHIBIT 29**



# Medical Suitability for Expatriate Assignment History & Physical Examination

GO-146-MSEA

Mark Snookal  
CAI - MVZM

07/24/15

RECEIVED

JUL 24 2019

Initial  
Nigeria

Note to Examinee and Examiner: In the US, the Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information for any U.S. based employees (whether within the U.S. or outside the U.S. on assignment) when responding to this request for medical information. 'Genetic information' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services. Local or Host Country legal requirements may also apply.

## Part A: Examinee: Please complete Parts A through F prior to exam:

| F.I.              | M.I.           | Last Name                 | First Name                      | CAI                         | Gender                        |
|-------------------|----------------|---------------------------|---------------------------------|-----------------------------|-------------------------------|
|                   |                | Mark                      | Snookal                         | MVZM                        | M                             |
| Current Job Title | New Job Title* | IEA Reliability Team Lead | Reliability Engineering Manager | Current Company/BU/OpCo ESE | Next * Company/BU/OpCo NMASBU |
| Location          | Location       | El Segundo, CA USA        | Nigeria                         | Location                    | Escravos, Nigeria             |

\*If Applicable

Part B: Your country of assignment may or may not have full medical resources to support your health needs. Please answer the following questions as accurately as possible and check 'N' (no) or 'Y' (yes) in the column. Answers with Yes, please provide more information in the description boxes. This information is used to promote your safety and ensure your health needs can be met.

|     |   | N                                   | Y                                   | Description  |
|-----|---|-------------------------------------|-------------------------------------|--|
| 1.  | Do you have any medical, physical or psychological conditions under the care of a health professional? If yes, please describe.   | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | I have a dilated aortic root. I am under the care of a cardiologist and see him once per year for a checkup. I have consulted with him on this assignment and he sees no issues with it. |
| 2.  | (a) Are you taking any medicines that require a prescription? If yes, please list.<br><br>(b) Are you taking any non-prescription medicines on a frequent basis? If yes, please list. | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | Losartan and Amlodipine  |
| 3.  | (a) Do you have any allergies?<br><br>(b) Have you ever had severe allergic reactions? If yes, do you know what caused it?  | <input checked="" type="checkbox"/> | <input type="checkbox"/>            |  |
| 4.  | Do you exercise for at least 30 minutes 3 times a week, on average?   | <input type="checkbox"/>            | <input checked="" type="checkbox"/> |  |
| 5.  | (a) Do you feel unusual fatigue or sleepiness?<br><br>(b) Do you have any problems sleeping?<br><br>(c) Do you use sleeping aids, including medication?                               | <input checked="" type="checkbox"/> | <input type="checkbox"/>            |  |
| 6.  | Have you ever experienced health problems working in extreme weather conditions?  | <input checked="" type="checkbox"/> | <input type="checkbox"/>            |  |
| 7.  | Have you experienced unexplained weight loss or gain?   | <input checked="" type="checkbox"/> | <input type="checkbox"/>            |  |
| 8.  | (a) Do you smoke? If yes, what and how much each day?<br><br>(b) Did you smoke regularly for more than 1 year ever in your past?  | <input checked="" type="checkbox"/> | <input type="checkbox"/>            |  |
| 9.  | Do you drink alcoholic beverages? If yes, what is your average weekly intake?   | <input checked="" type="checkbox"/> | <input type="checkbox"/>            |  |
| 10. | Have you ever required a medical evacuation from a work location? If yes, what was the reason?  | <input checked="" type="checkbox"/> | <input type="checkbox"/>            |  |

|  |  | Examinee Last and First Name<br>Mark Snookal |                                     | Examinee CAI<br>MYZM  |
|--|--|--|-------------------------------------|---|
| 11.  | Have you ever had any mental health or psychological issues requiring at least a medical prescription? If yes, please describe   | <input type="checkbox"/>                     | <input checked="" type="checkbox"/> | I was treated for depression with Effexor for a few years from approximately 1994-1996    |
| 12.  | Have you been in the emergency room and or hospitalized within the last six months?  | <input checked="" type="checkbox"/>          | <input type="checkbox"/>            |   |
| 13.  | Have you undergone any surgical procedure or operations within the last six months?  | <input checked="" type="checkbox"/>          | <input type="checkbox"/>            |   |
| 14.  | Did you have a physical (periodic, preventive) exam within the past two years?   | <input type="checkbox"/>                     | <input checked="" type="checkbox"/> |   |
| 15.  | Would you need health/medical resources for any disabling or special condition in the country of assignment?   | <input checked="" type="checkbox"/>          | <input type="checkbox"/>            |   |
| 16.  | Would you like to schedule a discussion with a Chevron Physician or Regional Medical Manager to discuss further a health condition or learn more about the host country medical resources?                       | <input checked="" type="checkbox"/>          | <input type="checkbox"/>            |   |
| 17.  | Does your new position require you to work or travel Offshore, In Field/Plant or Strictly Office? Please advise if you need additional certifications for your new position (e.g. HUET/BOSIET, Oil and Gas U.K.) | <input type="checkbox"/>                     | <input type="checkbox"/>            | My position is strictly office  |
| <b>Part C: Please answer the following questions and check 'N' (no) or 'Y' (yes) in the column. If 'Y' please describe.</b>          |  |  |                                     |   |
| Have you had any illness or condition related to the following body parts or systems? (minor conditions do not need to be mentioned) |  | N  | Y                                   | Description:  |
| 18.  | Head and Neck  | <input checked="" type="checkbox"/>          | <input type="checkbox"/>            |   |
| 19.  | Eyes or Visual   | <input checked="" type="checkbox"/>          | <input type="checkbox"/>            |   |
| 20.  | Ear, Nose and Throat   | <input checked="" type="checkbox"/>          | <input type="checkbox"/>            |   |
| 21.  | Teeth  | <input type="checkbox"/>                     | <input type="checkbox"/>            |   |
|  | (a) When was your last exam?   | <input type="checkbox"/>                     | <input type="checkbox"/>            |   |
|  | (b) Is there any dental work pending? Please describe  | <input checked="" type="checkbox"/>          | <input type="checkbox"/>            | 11/2017   |
| 22.  | (a) Chest such as shortness of breath, chronic cough.<br>(b) Breasts   | <input checked="" type="checkbox"/>          | <input type="checkbox"/>            |   |
| 23.  | Heart such as chest pain, palpitations or irregular beating  | <input type="checkbox"/>                     | <input checked="" type="checkbox"/> | I have PVC's which have been evaluated by a cardiologist and do not require any treatment |
| 24.  | Abdomen such as pain, hernias, abnormal bowel movement   | <input type="checkbox"/>                     | <input checked="" type="checkbox"/> | I had my gallbladder removed in 2014  |
| 25.  | Kidney, bladder or genital area  | <input checked="" type="checkbox"/>          | <input type="checkbox"/>            |   |
| 26.  | Spine and Musculo-skeletal, movement limitations or pain   | <input checked="" type="checkbox"/>          | <input type="checkbox"/>            |   |
| 27.  | Skin changes such as rash, spots, moles or itching   | <input checked="" type="checkbox"/>          | <input type="checkbox"/>            |   |
| 28.  | Epileptic seizures, dizzy spells or migraine   | <input checked="" type="checkbox"/>          | <input type="checkbox"/>            |   |
| 29.  | Diabetes or increase in blood sugar  | <input checked="" type="checkbox"/>          | <input type="checkbox"/>            |   |
| 30.  | Anemia or other blood conditions   | <input checked="" type="checkbox"/>          | <input type="checkbox"/>            |   |
| 31.  | Tuberculosis (TB) or positive TB test, skin or blood (e.g. TB spot, IGRA/Quantiferon®)   | <input checked="" type="checkbox"/>          | <input type="checkbox"/>            |   |
| 32.  | Any other health problems<br>(Please use space below. If need, use back page)  | <input checked="" type="checkbox"/>          | <input type="checkbox"/>            |   |
|  |  |  |                                     |   |

Examinee Last and First Name

Mark Snookal

Examinee CAI

MVZM

**Part D: Exposure History (Employee Only)**

Have you ever been exposed at work to dusts, solvents, other chemicals or any other known workplace hazards, e.g. biological agents?

Yes  No

If YES, please list agents with dates and for how long:

I have worked in industrial and petrochemical locations from 1990 - present

Have you ever been exposed in the workplace to:

Noise  Radiation/X-ray Equipment  Vibrating Hand Tools  Repetitive Movement  Weight Lifting  Other

If you checked one of the boxes above, please specify for how long, and whether Personal Protective Equipment (PPE) was used:

In my work in industrial and petrochemical locations from 1990 - present I have been exposed to noise but have always used PPE

**Part E: Occupational History (Employee Only)**

Have you ever been part of a medical (health) surveillance program through your work due to exposure to workplace hazards? e.g. Part of a hearing conservation program due to exposure to workplace noise.

Yes  No

If YES, please list with dates:

I am currently in a hearing conservation program in my employment with Chevron El Segundo

**Part F: Family History**

To comply with the US Genetic Information Nondiscrimination Act of 2008, this part should NOT be completed for any US-based employees (whether in the US or outside the US on assignment). Any information inadvertently provided for a US employee in this section should be redacted if the form is to be sent to the US for filing in the employee's medical record. Local related legislation may be also applicable.

Are there any medical conditions within your family relevant to be mentioned?

Physician Comments:

Have you ever been employed with Chevron or examined for employment by Chevron?

No  Yes If yes, when At hiring at Chevron El Segundo in 2009

**EXAMINEE:**

I certify that the information given by me is true and I authorize the examiner to furnish the results of this examination and other related medical investigation results to either the Chevron Regional Medical Managers or the Chevron Global Health and Medical facility. I acknowledge and agree that the results of this medical evaluation are managed by Chevron in a secure and confidential data system that will store and may transmit information to countries other than where the medical examination takes place, including but not limited to the U.S.

**FOR APPLICANT ONLY:** I understand that any misrepresentation, false statement or omission herein may result in the company rejecting my application, withdrawing any offer of employment, or terminating my employment at any time.

Examinee Signature

Date (mm/dd/yyyy)

7/18/2019

Examinee Last and First Name

Mark Snookal

Examinee CAI

MVZM

**Part G. PHYSICAL EXAMINATION: To be completed by Health Care Provider.****Vital Signs**

| HEIGHT<br>ft/cm | WEIGHT<br>lb/kg | BMI  | Abdominal Circum-<br>ference<br>in/cm | B.P.<br>(mmHg) | PULSE | Temperature<br>(°C/F) |
|-----------------|-----------------|------|---------------------------------------|----------------|-------|-----------------------|
| 72 "            | 256 lbs         | 34.7 |                                       | 135/78         | 53    | 97.5                  |

**Vision**

|      | Uncorrected |           |           | Corrected |           |           | Depth | Tonometry | Color Vision | Visual Fields |
|------|-------------|-----------|-----------|-----------|-----------|-----------|-------|-----------|--------------|---------------|
|      | Both        | Right     | Left      | Both      | Right     | Left      |       |           |              |               |
| Far  | 20/<br>6/   | 20/<br>6/ | 20/<br>6/ | 20/<br>6/ | 20/<br>6/ | 20/<br>6/ |       |           |              |               |
| Near | J#          | J#        | J#        | J# / +    | J# / +    | J# / +    |       |           |              | Normal        |

| N                                   | A                        | N = Normal. A = Abnormal, please describe           | DESCRIPTION            |
|-------------------------------------|--------------------------|---|------------------------|
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | 1. General Appearance                               |                        |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | 2. Head   |                        |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | 3. Ear, Nose Mouth and Throat                       |                        |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | 4. Neck   |                        |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | 5. Eyes   |                        |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | 6. Chest  |                        |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | 7. Breasts  |                        |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | 8. Respiratory System                               | occas ectopics (PVC's) |
| <input type="checkbox"/>            | <input type="checkbox"/> | 9. Cardiovascular System                            |                        |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | 10. Abdomen, Viscera/Hernias                        |                        |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | 11. Genito-urinary                                  |                        |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | 12. Lower GI Tract                                  |                        |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | 13. Extremities                                     |                        |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | 14. Spine and Musculo-skeletal.<br>Range of Motion. |                        |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | 15. Skin and Lymphatic System                       |                        |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | 16. Central Nervous System                          |                        |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | 17. Peripheral Nervous System Reflexes              |                        |
| <input type="checkbox"/>            | <input type="checkbox"/> | 18. Others, please specify                          |                        |

Examinee Last and First Name

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## LABORATORY AND SPECIAL TESTS

| N                                   | A                                   | Not Done                            | AS INDICATED              | RESULTS. N = Normal. A = Abnormal, please describe |
|-------------------------------------|-------------------------------------|-------------------------------------|---------------------------|--|
| <input type="checkbox"/>            | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | Audiogram                 |  |
| <input type="checkbox"/>            | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | Chest X Ray               |  |
| <input checked="" type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/>            | Complete Blood Count      |  |
| <input type="checkbox"/>            | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | Drug Screening            |  |
| <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/>            | ECG                       |  |
| <input type="checkbox"/>            | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | Pulmonary Function        |  |
| <input checked="" type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/>            | Serum Profile/Chemistries |  |
| <input type="checkbox"/>            | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | Stress Test               |  |
| <input checked="" type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/>            | Urinalysis                |  |
| <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | Others, please specify    |  |

REMARKS: Describe significant / abnormal findings/limitations noted above (if need, please use back page)

① PVCs - frequent asymptomatic followed by cardiology  
 ② Dilated aortic root followed by cardiology  
 ongoing At studies yearly Echo vs CT chest  
 Stable on meds

If any abnormalities were found during the examination, was examinee informed?  Yes  No

## Part H: MEDICAL RECOMMENDATION

| H.1. Fitness for Duty Classification, ONLY FOR INTERNAL CHEVRON USE |   | H.2. Restrictions pertinent to Job Requirements (refer to GO-308)                                 |
|---|---|---|
| <input type="checkbox"/>  | A. Fit for Duty   |   |
| <input checked="" type="checkbox"/>                                 | B. Fit for Duty with Restrictions                       | NO heavy lifting >50 lbs<br>needs review of<br>recommend letter from<br>cardiologist to clear him |
| <input type="checkbox"/>  | C. Not Fit for Duty                                     |   |
| <input type="checkbox"/>  | D. Failed to comply with requested evaluations, due to: |   |

|  |                                     |                                     |                                |                    |
|--|-------------------------------------|-------------------------------------|--------------------------------|--------------------|
| Examiner's Name (please print)<br><b>IRVING SOBEL MD</b> | Signature<br><i>Irving Sobel MD</i> | Date (mm/dd/yyyy) <b>07/24/2015</b> |                                |                    |
| Address <b>4076 ADMIRALTY WAY</b>                        | City <b>MARINA DA</b>               | State / Province <b>WA</b>          | Postal / Zip Code <b>98108</b> | Country <b>USA</b> |

|   |           |                   |
|---|-----------|-------------------|
| Chevron Global Health & Medical Approval<br>(please print name) | Signature | Date (mm/dd/yyyy) |
|---|-----------|-------------------|

|  |                      |
|--|----------------------|
| Examinee Last and First Name<br>Mark Snookal | Examiner C/I<br>MVZM |
|--|----------------------|

PLEASE ATTACH COPIES OF IMPORTANT REPORTS OF CURRENT INTEREST.  
If available, Form GO-308 (Physical Requirements and Working Conditions) must be included.